

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached for use by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5503
CERTIFICATE OF DEATH

Reg. Dist. No. 05499
290

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial</u>		d. STREET ADDRESS <u>40</u>	
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>R.</u> Last <u>Callahan</u>		4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 30, 1905</u>
9. AGE (In years, last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Kinnamon</u>		14. MOTHER'S MAIDEN NAME <u>Cora Price</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Carroll C. Callahan</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>175X</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u> DUE TO <u>Overturning of ovary</u> (c) <u>Overturning of ovary</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>11:05</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>219 S. Washington Street, Easton, Maryland</u> DATE SIGNED <u>14 May 56</u>			
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>		M.D. <u>219 S. Washington Street, Easton, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>		DATE <u>5/16/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5/16/56</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton</u> <u>md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert [unclear]</u>		ADDRESS <u>Easton</u>	
24a. REC'D BY REGISTRAR DATE <u>5/16/56</u>		24b. REGISTRAR'S SIGNATURE <u>N.H. Neeress</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF DEATH	
5. PLACE OF DEATH		6. CAUSE OF DEATH		7. MANNER OF DEATH		8. SIGNATURE OF REGISTRAR	
9. SIGNATURE OF DECEASED		10. SIGNATURE OF WITNESS		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF CLERK	
13. SIGNATURE OF CHURCH		14. SIGNATURE OF FUNERAL HOME		15. SIGNATURE OF BURIAL		16. SIGNATURE OF CREMATION	
17. SIGNATURE OF INTERMENT		18. SIGNATURE OF REINTERMENT		19. SIGNATURE OF REINTERMENT		20. SIGNATURE OF REINTERMENT	
21. SIGNATURE OF REINTERMENT		22. SIGNATURE OF REINTERMENT		23. SIGNATURE OF REINTERMENT		24. SIGNATURE OF REINTERMENT	
25. SIGNATURE OF REINTERMENT		26. SIGNATURE OF REINTERMENT		27. SIGNATURE OF REINTERMENT		28. SIGNATURE OF REINTERMENT	
29. SIGNATURE OF REINTERMENT		30. SIGNATURE OF REINTERMENT		31. SIGNATURE OF REINTERMENT		32. SIGNATURE OF REINTERMENT	
33. SIGNATURE OF REINTERMENT		34. SIGNATURE OF REINTERMENT		35. SIGNATURE OF REINTERMENT		36. SIGNATURE OF REINTERMENT	
37. SIGNATURE OF REINTERMENT		38. SIGNATURE OF REINTERMENT		39. SIGNATURE OF REINTERMENT		40. SIGNATURE OF REINTERMENT	
41. SIGNATURE OF REINTERMENT		42. SIGNATURE OF REINTERMENT		43. SIGNATURE OF REINTERMENT		44. SIGNATURE OF REINTERMENT	
45. SIGNATURE OF REINTERMENT		46. SIGNATURE OF REINTERMENT		47. SIGNATURE OF REINTERMENT		48. SIGNATURE OF REINTERMENT	
49. SIGNATURE OF REINTERMENT		50. SIGNATURE OF REINTERMENT		51. SIGNATURE OF REINTERMENT		52. SIGNATURE OF REINTERMENT	
53. SIGNATURE OF REINTERMENT		54. SIGNATURE OF REINTERMENT		55. SIGNATURE OF REINTERMENT		56. SIGNATURE OF REINTERMENT	
57. SIGNATURE OF REINTERMENT		58. SIGNATURE OF REINTERMENT		59. SIGNATURE OF REINTERMENT		60. SIGNATURE OF REINTERMENT	
61. SIGNATURE OF REINTERMENT		62. SIGNATURE OF REINTERMENT		63. SIGNATURE OF REINTERMENT		64. SIGNATURE OF REINTERMENT	
65. SIGNATURE OF REINTERMENT		66. SIGNATURE OF REINTERMENT		67. SIGNATURE OF REINTERMENT		68. SIGNATURE OF REINTERMENT	
69. SIGNATURE OF REINTERMENT		70. SIGNATURE OF REINTERMENT		71. SIGNATURE OF REINTERMENT		72. SIGNATURE OF REINTERMENT	
73. SIGNATURE OF REINTERMENT		74. SIGNATURE OF REINTERMENT		75. SIGNATURE OF REINTERMENT		76. SIGNATURE OF REINTERMENT	
77. SIGNATURE OF REINTERMENT		78. SIGNATURE OF REINTERMENT		79. SIGNATURE OF REINTERMENT		80. SIGNATURE OF REINTERMENT	
81. SIGNATURE OF REINTERMENT		82. SIGNATURE OF REINTERMENT		83. SIGNATURE OF REINTERMENT		84. SIGNATURE OF REINTERMENT	
85. SIGNATURE OF REINTERMENT		86. SIGNATURE OF REINTERMENT		87. SIGNATURE OF REINTERMENT		88. SIGNATURE OF REINTERMENT	
89. SIGNATURE OF REINTERMENT		90. SIGNATURE OF REINTERMENT		91. SIGNATURE OF REINTERMENT		92. SIGNATURE OF REINTERMENT	
93. SIGNATURE OF REINTERMENT		94. SIGNATURE OF REINTERMENT		95. SIGNATURE OF REINTERMENT		96. SIGNATURE OF REINTERMENT	
97. SIGNATURE OF REINTERMENT		98. SIGNATURE OF REINTERMENT		99. SIGNATURE OF REINTERMENT		100. SIGNATURE OF REINTERMENT	

BUREAU V. S.

MAY 21 1956

RECEIVED

TO HEALTH DEPARTMENT OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5522

CERTIFICATE OF DEATH

Reg. Dist. No.

05500

190

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Hilda</u> First <u>Mae</u> Middle <u>Campher</u> Last		4. DATE OF DEATH Month <u>5</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/27/26</u>
9. AGE (In years last birthday) <u>29</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isiah Freeman</u>		14. MOTHER'S MAIDEN NAME <u>Irene Purnell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocarditis</u> <u>648.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pregnancy</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 14</u> , 19 <u>56</u> to <u>May 26</u> , 19 <u>56</u> ; that I last saw the deceased alive on <u>May 26</u> , 19 <u>56</u> , and that death occurred at <u>7:30</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton, Md.</u> DATE SIGNED <u>5/29/56</u>			
ACTUAL SIGNATURE <u>Hayward I. Pratt</u> M.D.		PHYSICIAN'S NAME (Type) <u>Easton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/29/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Trappe Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Trappe Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Blostwick</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	
ADDRESS <u>Easton, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Nowing</u>	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death	
Mrs. Campbell		Female		28		10/1/20		10/1/20		Boston, Mass.		Disease		Suicide	
Residence		Married		USA		Occupation		Profession		Education		Religion		Race	
Boston, Mass.		Yes		USA		Teacher		High School		Catholic		Caucasian		Caucasian	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Forensic Physician		Signature of Toxicologist		Signature of Bacteriologist	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 3

JUN 4 1956

RECEIVED

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5504
CERTIFICATE OF DEATH

05501
Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>2 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTON MEMORIAL HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MAY</u> Middle <u>D.</u> Last <u>CASSON</u>		4. DATE OF DEATH Month <u>5</u> Day <u>17</u> Year <u>1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 1 - 1890</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN DAVIS</u>		14. MOTHER'S MAIDEN NAME <u>HENRIETTA CAMPBELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr Edward R. Casson</u> Address <u>(Same)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left ventricular aneurysm</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>97 - yersoidal defect, old</u> DUE TO <u>Coronary occlusion</u> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.		ADDRESS (Street, city or town, state) <u>219 S. Washington St</u> DATE SIGNED <u>17 May</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		<u>Easton, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>May 19, 1966</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin E. Newman</u> ADDRESS <u>Easton Md</u>		24a. REC'D BY REGISTRAR <u>5/19/66</u>	24b. REGISTRAR'S SIGNATURE <u>N. A. Newey</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

5505

CERTIFICATE OF DEATH

05502

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Buck</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u> 75x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>32 Graham st</u>		d. STREET ADDRESS <u>125 Morris st.</u>	
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>Coard</u> Last <u>Coard</u>		4. DATE OF DEATH Month <u>5</u> Day <u>3</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Ca</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/21/1900</u> 55 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hauling</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George Coard</u>		14. MOTHER'S MAIDEN NAME <u>Hettie Ayers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>2</u>		16. SOCIAL SECURITY NO. <u>195-05-9419</u>	
17. INFORMANT <u>Elaine Coard</u> Address <u>Easton, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right Hemiplegia</u> <u>334x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Gen Art Def.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>yes</u> <u>yes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4-26</u> , 19 <u>56</u> , to <u>5-3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-2</u> , 19 <u>56</u> , and that death occurred at <u>5:30</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. F. Buell</u> M.D.		ADDRESS (Street, city or town, state) <u>19 Goldsborough Rd Easton Md</u> DATE SIGNED <u>5-7-56</u>	
PHYSICIAN'S NAME (Type) <u>M. F. Buell MD.</u>		<u>Easton Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/8/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sandtown cem</u>	22d. LOCATION (City, town, or county) (State) <u>Hillsboro Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashiell</u> ADDRESS <u>Easton, Md</u>		24a. REC'D BY REGISTRAR <u>DATE 5/8/56</u>	24b. REGISTRAR'S SIGNATURE <u>N. H. Newberry</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		MAY 10 1956	
AGE		SEX	
65		M	
RACE		EDUCATION	
W		H	
OCCUPATION		CAUSE OF DEATH	
Carpenter		Heart Disease	
PLACE OF DEATH		MANNER OF DEATH	
Home		Natural	
CITY		COUNTY	
BALTIMORE		BALTIMORE	
STATE		FEDERAL BUREAU OF INVESTIGATION	
MAY 11 1956		MAY 11 1956	

BUREAU V. S.

MAY 11 1956

RECEIVED

TO BE COMPLETED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5523

CERTIFICATE OF DEATH

05503

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route II</u>		d. STREET ADDRESS <u>Route 2 Box 175A</u>	
3. NAME OF DECEASED (Type or print) <u>Blaise Rose Mary</u>		4. DATE OF DEATH Month <u>5</u> Day <u>14</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/6/54</u>
9a. AGE (In years last birthday) <u>1</u> yrs.		9b. IF UNDER 1 YEAR Months <u>1</u> Days <u>14</u> Hours <u>19</u> Min. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Melvin Fells</u>		14. MOTHER'S MAIDEN NAME <u>Elsie Madaniel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Mrs Edsie Fells Easton, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>475X</u> DUE TO <u>Upper Respiratory Infection</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>This child had a congenital defect of legs, never walked</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-12</u> , 19 <u>56</u> , to <u>5-14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-12</u> , 19 <u>56</u> , and that death occurred at <u>5 a.m.</u> from the causes and on the date stated above. Coroner - <u>Walter H. Smith</u>			
ACTUAL SIGNATURE <u>W. F. Smith</u>		M.D. <u>19 goldsboro Rd</u> DATE SIGNED <u>5-17-56</u>	
PHYSICIAN'S NAME (Type) <u>M.F. Bue UMD</u>		<u>19941broad St Easton Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>5/17/56</u>	<u>Richards Cem</u>	<u>Easton MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>JAMES B. DASHIELL, Easton, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 5/23/56</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Mrs. M. H. Nerning</u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, and cause of death. The form is partially filled out with handwritten text.

NAME: *John Doe*
DATE: *7/10/54*
TIME: *1:00 PM*
PLACE: *Home*
CAUSE OF DEATH: *Heart Disease*

RECEIVED
MAY 23 1956
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5524

Reg. Dist. No. 291

06559

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) nr Poplar Island		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 1517 DeSoto Rd	
3. NAME OF DECEASED (Type or print) First Louis Middle G Last Florey Jr		4. DATE OF DEATH Month 5 Day 10 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1936
9. AGE (In years last birthday) 19 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) airman		10b. KIND OF BUSINESS OR INDUSTRY AF US	
11. BIRTHPLACE (State or foreign country) Baltimore md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis J. Florey Jr.		14. MOTHER'S MAIDEN NAME Anna Kessler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215-34-1753	
17. INFORMANT Louis J. Florey, Balto md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 860X DUE TO airplane crash Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) body recovered 5-5-56 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) airplane crash 5-10-56	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Louis S. Melty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Louis S. MELTY		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 6/8/56	
22c. NAME OF CEMETERY OR CREMATORY Western Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore md	
23. FUNERAL DIRECTOR'S SIGNATURE L. Hamletta Harrison, St. Michael's		ADDRESS	
24a. REC'D BY REGISTRAR June 6, 56		24b. REGISTRAR'S SIGNATURE Mrs. P. R. Beth	

MEDICAL CERTIFICATION

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further action is necessary, please see the instructions on the back of this form. The death certificate should be filed with the Registrar of the Department of Health, Baltimore, Maryland. The death certificate should be filed with the Registrar of the Department of Health, Baltimore, Maryland. The death certificate should be filed with the Registrar of the Department of Health, Baltimore, Maryland.

MAINT AND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 12 1956

RECEIVED

5525

CERTIFICATE OF DEATH

Reg. Dist. No. 0550490

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Royal Oak</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Royal Oak</u>			
3. NAME OF DECEASED (Type or print) <u>Lvda</u> First <u>C</u> Middle <u>Hynson</u> Last				4. DATE OF DEATH Month <u>5</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/16/74</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Harris</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>George Wallace</u> Address <u>Royal Oak, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure -</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cachexia - generalized</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>-</u> 19 <u>56</u> p. m. <u>-</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>	
20f. (City or town) <u>-</u>				(County) <u>-</u>		(State) <u>-</u>	
21. I certify that I attended the deceased from <u>9-28</u> , 19 <u>53</u> to <u>5-18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-18</u> , 19 <u>56</u> , and that death occurred at <u>10:30</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm M. Reeser Jr</u>				DATE SIGNED <u>5-26-56</u>			
SIGNATURE (Type) <u>Wm M. Reeser Jr</u>				ADDRESS (Street, city or town, state) <u>St Michaels Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/26</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Royal Oak Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Royal Oak, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Doherty</u>				ADDRESS <u>Easton, Md</u>		24a. REC'D BY REGISTRAR <u>DATE 4 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>N. H. Reeser Jr</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained from the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1956 4 NDE

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5526

CERTIFICATE OF DEATH

05505

291

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Talbot		STATE Md. COUNTY Talbot		CITY (If outside corporate limits, write RURAL and give nearest town) McDaniel, Md.		CITY (If outside corporate limits, write RURAL and give nearest town) McDaniel, Md.	
CITY OR TOWN McDaniel, Md.		LENGTH OF STAY (In this place) Life		STREET ADDRESS -----		STREET ADDRESS (If rural give location) -----	
HOSPITAL OR INSTITUTION OR STREET ADDRESS -----				STREET ADDRESS (If rural give location) -----			
3. NAME OF DECEASED (First) LEWEL (Middle) P. (Last) KERSEY				4. DATE OF DEATH (Month) May (Day) 12 (Year) 1956			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH April 26, 1881	9. AGE last birthday 75 yrs.	IF UNDER 1 YEAR Months ----- Days -----		IF UNDER 24 HRS. Hours ----- Min. -----
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) McDaniel, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Kersey				14. MOTHER'S MAIDEN NAME Ellen Vincent			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Mrs. Leona B. Kersey, McDaniel, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) Serious hemorrhage from lungs				INTERVAL BETWEEN ONSET AND DEATH 15 minutes			
ANTECEDENT CAUSE(S) DUE TO (B) Pulmonary Tuberculosis				4 mo			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) influenza in Jan 1956							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1955 to May 12, 1956 , that I last saw the deceased alive on May 5, 1956 , and that death occurred at 4 P.M. from the causes and on the date stated above.							
SIGNATURE Y. M. R. S.				DATE SIGNED May 15, 1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				NAME OF CEMETERY OR CREMATORY Olivet Cemetery			
DATE THEREOF May 15, 1956		LOCATION (City, town, or county) St. Michaels, Md.		24. REC'D BY REGISTRAR Mr. Robert R. S.		25. FUNERAL DIRECTOR'S SIGNATURE St. Michaels, Md.	
24. REC'D BY REGISTRAR May 15, 1956		REGISTRAR'S SIGNATURE Mr. Robert R. S.		25. FUNERAL DIRECTOR'S SIGNATURE St. Michaels, Md.		ADDRESS St. Michaels, Md.	

CERTIFICATE OF DEATH

2228

1956

IN DEATH OF

DATE OF DEATH

NAME OF DECEASED
RESIDENCE
CITY
STATE
COUNTRY

DATE OF BIRTH
PLACE OF BIRTH
CITY
STATE
COUNTRY

DATE OF DEATH
PLACE OF DEATH
CITY
STATE
COUNTRY

DATE OF DEATH
PLACE OF DEATH
CITY
STATE
COUNTRY

DATE OF DEATH
PLACE OF DEATH
CITY
STATE
COUNTRY

DATE OF DEATH
PLACE OF DEATH
CITY
STATE
COUNTRY

DATE OF DEATH
PLACE OF DEATH
CITY
STATE
COUNTRY

DATE OF DEATH
PLACE OF DEATH
CITY
STATE
COUNTRY

DATE OF DEATH
PLACE OF DEATH
CITY
STATE
COUNTRY

DATE OF DEATH
PLACE OF DEATH
CITY
STATE
COUNTRY

BUREAU V. S.

MAY 18 1956

RECEIVED

4-11-56 R 148 14

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>		c. LENGTH OF STAY IN 1b <u>5 1/2 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>80 Memorial Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lila</u> Middle <u>LEROUX</u> Last <u>LEROUX</u>		4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 3 1897</u>
9. AGE (In years, last birthday) <u>59</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Roy McCully</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Benjamin Leroux Greensboro Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X apoplexy</u> DUE TO (b) <u>1st C.V.D.</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/21, 1956</u> , to <u>5/21, 1956</u> , that I last saw the deceased alive on <u>5/21, 1956</u> , and that death occurred at <u>7:12 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. Cox</u>		DATE SIGNED <u>5/21/56</u>	
PHYSICIAN'S NAME (Type) <u>J. E. Boulaie</u>		ADDRESS <u>Greensboro Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/5/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>	22d. LOCATION (City, town, or county) (State) <u>Greensboro Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulaie</u>		24. REC'D BY REGISTRAR <u>5/5/56</u>	
ADDRESS <u>Greensboro Md.</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Meier</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION	
7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH	
10. MEDICAL HISTORY		11. PRESENT ILLNESS		12. POST-MORTEM	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF BURIAL PLACE		18. SIGNATURE OF STATE DEPARTMENT OF HEALTH	
19. SIGNATURE OF COUNTY CLERK		20. SIGNATURE OF CITY CLERK		21. SIGNATURE OF VICE-MAYOR	
22. SIGNATURE OF MAYOR		23. SIGNATURE OF COMMISSIONER OF HEALTH		24. SIGNATURE OF ASSISTANT COMMISSIONER OF HEALTH	
25. SIGNATURE OF DEPUTY COMMISSIONER OF HEALTH		26. SIGNATURE OF CHIEF CLERK		27. SIGNATURE OF CLERK	
28. SIGNATURE OF CLERK		29. SIGNATURE OF CLERK		30. SIGNATURE OF CLERK	
31. SIGNATURE OF CLERK		32. SIGNATURE OF CLERK		33. SIGNATURE OF CLERK	
34. SIGNATURE OF CLERK		35. SIGNATURE OF CLERK		36. SIGNATURE OF CLERK	
37. SIGNATURE OF CLERK		38. SIGNATURE OF CLERK		39. SIGNATURE OF CLERK	
40. SIGNATURE OF CLERK		41. SIGNATURE OF CLERK		42. SIGNATURE OF CLERK	
43. SIGNATURE OF CLERK		44. SIGNATURE OF CLERK		45. SIGNATURE OF CLERK	
46. SIGNATURE OF CLERK		47. SIGNATURE OF CLERK		48. SIGNATURE OF CLERK	
49. SIGNATURE OF CLERK		50. SIGNATURE OF CLERK		51. SIGNATURE OF CLERK	
52. SIGNATURE OF CLERK		53. SIGNATURE OF CLERK		54. SIGNATURE OF CLERK	
55. SIGNATURE OF CLERK		56. SIGNATURE OF CLERK		57. SIGNATURE OF CLERK	
58. SIGNATURE OF CLERK		59. SIGNATURE OF CLERK		60. SIGNATURE OF CLERK	
61. SIGNATURE OF CLERK		62. SIGNATURE OF CLERK		63. SIGNATURE OF CLERK	
64. SIGNATURE OF CLERK		65. SIGNATURE OF CLERK		66. SIGNATURE OF CLERK	
67. SIGNATURE OF CLERK		68. SIGNATURE OF CLERK		69. SIGNATURE OF CLERK	
70. SIGNATURE OF CLERK		71. SIGNATURE OF CLERK		72. SIGNATURE OF CLERK	
73. SIGNATURE OF CLERK		74. SIGNATURE OF CLERK		75. SIGNATURE OF CLERK	
76. SIGNATURE OF CLERK		77. SIGNATURE OF CLERK		78. SIGNATURE OF CLERK	
79. SIGNATURE OF CLERK		80. SIGNATURE OF CLERK		81. SIGNATURE OF CLERK	
82. SIGNATURE OF CLERK		83. SIGNATURE OF CLERK		84. SIGNATURE OF CLERK	
85. SIGNATURE OF CLERK		86. SIGNATURE OF CLERK		87. SIGNATURE OF CLERK	
88. SIGNATURE OF CLERK		89. SIGNATURE OF CLERK		90. SIGNATURE OF CLERK	
91. SIGNATURE OF CLERK		92. SIGNATURE OF CLERK		93. SIGNATURE OF CLERK	
94. SIGNATURE OF CLERK		95. SIGNATURE OF CLERK		96. SIGNATURE OF CLERK	
97. SIGNATURE OF CLERK		98. SIGNATURE OF CLERK		99. SIGNATURE OF CLERK	
100. SIGNATURE OF CLERK		101. SIGNATURE OF CLERK		102. SIGNATURE OF CLERK	

RECEIVED
MAY 11 1956
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05507

5527

CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>TALBOT</u>		STATE <u>MARYLAND</u>		COUNTY <u>TALBOT</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>WITTMAN</u>		<u>LIFE</u>		TOWN <u>WITTMAN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>RURAL</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>CHARLES</u> (Middle) <u>M.</u> (Last) <u>MARSHALL</u>				(Month) <u>MAY</u> (Day) <u>2</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>WHITE</u>	<u>WIDOWED</u>	<u>JUNE 26 1871</u>	<u>84</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>MECHANIC</u>		<u>GENERAL</u>		<u>WITTMAN</u>		<u>U.S.A</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>WILLIAM J. MARSHALL</u>				<u>HARRIET JANE MARSHALL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>NONE</u>		<u>Herman Marshall Witman</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A)				<u>coronary atherosclerosis</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>chronic valvular disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<u>hypertension</u>			
(C)				<u>atherosclerosis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		INTERVAL BETWEEN SUNSET AND DEATH	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		<u>minutes</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 1, 1956</u> to <u>May 2, 1956</u> , that I last saw the deceased alive on <u>May 1, 1956</u> , and that death occurred at <u>3:15</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Herman Marshall Witman</u> M.D.				DATE SIGNED <u>May 3 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>MAY 4 1956</u>		<u>WILVET CEMETERY</u>		<u>ST. MICHAELS, MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>May 8, 56</u>		<u>Wm Paul L. Bell</u>		<u>St. Hampton Harrison</u>		<u>St. Michaels, Md</u>	

CERTIFICATE OF DEATH

7553

NAME OF DECEASED

DATE OF BIRTH

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

BUREAU V. S.

MAY 11 1950

RECEIVED

NOTED

5507

CERTIFICATE OF DEATH

Reg. Dist. No 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 EASTON</u>	c. LENGTH OF STAY IN 1b <u>9 hrs - 18 min.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Thman</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hosp.</u>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>V</u> Last <u>Marshall</u>		4. DATE OF DEATH Month <u>5</u> Day <u>8</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 24 - 1902</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Edward Willey</u>	
14. MOTHER'S MARDEN NAME <u>Marshall</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Addison C. Marshall (husb)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas, metastatic</u> <u>157X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>to liver, lung, adrenals, & pleurae</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>6:50 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.		ADDRESS (Street, city or town, State) <u>219 S. Washington ST. 9 May 56</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		DATE SIGNED <u>May 56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 10, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Christ Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>St. Michaels Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel Harrison</u> ADDRESS <u>St. Michaels</u>		24a. REC'D BY REGISTRAR <u>5/10/56</u>	24b. REGISTRAR'S SIGNATURE <u>N. H. Neuman</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5527

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		AGE	
SEX		RACE	
BIRTH DATE		BIRTH PLACE	
EDUCATION		OCCUPATION	
MARRIAGE		RELIGION	
PREVIOUS ILLNESS		HISTORY OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. 1

MAY 16 1956

RECEIVED

5508

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>			d. STREET ADDRESS <u>218 S. Aurora St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>LEVIN</u> Middle <u>F.</u> Last <u>MORRIS</u>			4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>1956</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 12, 1898</u>		9. AGE (In years last birthday) <u>57</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Industrial Acc. Insurance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State of Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
13. FATHER'S NAME <u>John T. D. MORRIS</u>			14. MOTHER'S MAIDEN NAME <u>Minnie E. Hogg</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Edythe S. Morris</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>420.1</u> DUE TO <u>CORONARY OCCLUSION</u> (c) <u>420.1</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>5-9-</u> , 19 <u>56</u> , to <u>5-15-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-15-</u> , 19 <u>56</u> , and that death occurred at <u>8:15 P.</u> M., from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>		M.D. <u>219 S. Washington St.</u>		DATE SIGNED <u>16 May 56</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		<u>Easton, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/18/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. E. Schuman</u>		ADDRESS <u>Easton Md</u>		24a. REC'D BY REGISTRAR <u>DATE 5/18/56</u>	24b. REGISTRAR'S SIGNATURE <u>N. H. Neer</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One of Two

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MAYNARD		MALE		45		JAN 1 1911		BALTIMORE		MD		MD		USA	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
JAN 1 1956		10:00 AM		BALTIMORE		MD		MD		USA		HEART DISEASE		NATURAL	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED		MARRIED		MARRIED	
BALTIMORE		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED	
DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		STATE OF MARRIAGE		COUNTRY OF MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
JAN 1 1956		BALTIMORE		MD		MD		USA		HEART DISEASE		NATURAL		NATURAL	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED		MARRIED		MARRIED	
BALTIMORE		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED	
DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		STATE OF MARRIAGE		COUNTRY OF MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
JAN 1 1956		BALTIMORE		MD		MD		USA		HEART DISEASE		NATURAL		NATURAL	

BUREAU V. 2

MAY 21 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5509 CERTIFICATE OF DEATH

05510

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i> c. LENGTH OF STAY IN 1b <i>11 days</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Caroline</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Federalburg - Rural</i> d. STREET ADDRESS <i>05X-2</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <i>Joseph</i> Middle <i>Kearnes</i> Last <i>Newton</i>		4. DATE OF DEATH Month <i>May</i> Day <i>21</i> Year <i>1956</i>		5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept 24, 1874</i>		9. AGE (In years last birthday) <i>81</i> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Paper Hanger</i>				10b. KIND OF BUSINESS OR INDUSTRY _____				11. BIRTHPLACE (State or foreign country) <i>Virginia</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>MR. Newton</i>						14. MOTHER'S MAIDEN NAME <i>Amanda Blinnac</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service) _____				16. SOCIAL SECURITY NO. <i>579-05-3622</i>				17. INFORMANT <i>Mrs. Lillie M. Newton (wife)</i> Address <i>Hospital Records</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> 600.0 DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>Chronic pyelonephritis</i> DUE TO _____ (c) <i>Congestive Heart failure</i> DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Benign prostatic hypertrophy, ASCVD</i>												INTERVAL BETWEEN ONSET AND DEATH <i>12 days</i> <i>2 Mon</i> <i>10 days</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) _____				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____									
20c. TIME OF INJURY Month _____ Day _____ Year <i>19</i> Hour _____ a. m. _____ p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that I attended the deceased from <i>April</i> , 1956, to <i>May 21</i> , 1956, that I last saw the deceased alive on <i>May 21</i> , 1956, and that death occurred at <i>6:40 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <i>R. C. Kingsbury</i> M.D. _____ PHYSICIAN'S NAME (Type) _____													
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>May 25, 1956</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>				22d. LOCATION (City, town, or county) <i>Washington, D.C.</i> (State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. Hampton</i>						ADDRESS <i>2400 Federalburg, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>5/25/56</i>		24b. REGISTRAR'S SIGNATURE <i>N. A. Neirin</i>			

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. S.

MAY 29 1956

RECEIVED

5510

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH o. COUNTY <i>TALBOT</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MARYLAND</i> b. COUNTY <i>TALBOT</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>40 EASTON</i>				c. LENGTH OF STAY IN 1b <i>2 days 5 hrs.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>301 HOLDSBORO STREET</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Amelia</i> Middle <i>M.</i> Last <i>NICHOLS</i>				4. DATE OF DEATH Month <i>5</i> Day <i>30</i> Year <i>1956</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>MAY 14 1894</i>	
9. AGE (In years last birthday) <i>62</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Henry Nichols</i>				14. MOTHER'S MAIDEN NAME <i>Florence Dawson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Miss Helen Hopkins (friend) Easton Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>175X Carcinomatosis, generalized</i> DUE TO <i>Carcinoma of the ovary</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>17 mos</i> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma of the breast</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>29 May</i> , 1956, to <i>30 May</i> , 1956, that I last saw the deceased alive on <i>30 May</i> , 1956, and that death occurred at <i>2:35</i> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>1 Kenneth Harrison</i> M.D.				ADDRESS (Street, city or town, state) <i>Easton Maryland</i> DATE SIGNED <i>June 56</i>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>6/1/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Easton Talbot Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Maurice E. Newman</i> ADDRESS <i>Easton Md</i>				24a. REC'D BY REGISTRAR DATE <i>6/1/56</i>		24b. REGISTRAR'S SIGNATURE <i>N. H. Neerues</i>	

MEDICAL CERTIFICATION

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be used by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1956 7 NOV

RECEIVED

5511

CERTIFICATE OF DEATH

Reg. Dist. No.

45512
05512
240

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Wesley</u> Middle <u>Nixon</u> Last <u>Nixon</u>				4. DATE OF DEATH Month <u>May</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 6, 1885</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>11</u> Hours <u>19</u> Min. <u>56</u>		IF UNDER 24 HRS. Months <u>7</u> Days <u>11</u> Hours <u>19</u> Min. <u>56</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butler</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Eva Nixon (wife)</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>It. C. U. D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>55</u> , to <u>5/11/56</u> , 19 <u>56</u> ; that I last saw the deceased alive on <u>5/11/56</u> , 19 <u>56</u> , and that death occurred at <u>8:35 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Easton Md</u> PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cemetery</u>		22d. LOCATION (City, town, or county) <u>Easton Maryland</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Boshell</u> ADDRESS <u>Easton, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 5/15/56</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Neenan</u>	

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5512

CERTIFICATE OF DEATH

05513

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greensboro</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Main Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>J.</u> Last <u>Pinder</u>		4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July - 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>65</u> yrs. <input type="checkbox"/> UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Pinder</u>		14. MOTHER'S MAIDEN NAME <u>Jane Hussey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Jennie Hartnett (sister)</u>		Address <u>Greensboro, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Apoplexy</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>a-c-v.d.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>902.0 Head injury 5-23-56</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall out of wheel chair, striking head - had bloody spinal fluid</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Greensboro</u> (County) <u>Caroline</u> (State) <u>Md</u>	
21. I certify that I attended the deceased from <u>5-1-56</u> to <u>5-25-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-1-56</u> , 19 <u>56</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Cox</u>		ADDRESS (Street, city or town, state) <u>Easton Md</u>	
DATE SIGNED			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/29/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>	22d. LOCATION (City, town, or county) (State) <u>Greensboro Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulaes</u>		ADDRESS <u>Greensboro Md</u>	
24a. REC'D BY REGISTRAR <u>5/29/56</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Neeriss</u>	

MEDICAL CERTIFICATION

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed with the hospital or attending physician. The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed with the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 4 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5513 CERTIFICATE OF DEATH

05514

Reg. Dist. No. 290

Item 7, Film G196 5-9-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>TALBOT</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>TALBOT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>40 TRAPPE EASTON</u>		<u>one day</u>		TOWN <u>TRAPPE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>86 MEMORIAL HOSP.</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Wm</u> (Middle) <u>CHARLES</u> (Last) <u>PRITCHETT</u>				(Month) <u>MAY</u> (Day) <u>1</u> (Year) <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9-11-1882</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
						Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter - self-employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>West Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>214-18-4342</u>		17. INFORMANT & ADDRESS <u>Mrs Marie RASSA</u>			
		(If Yes, give war or dates of service)					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>Heart failure</u>				1908 THAYER		TERRALE	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial Infarct</u>				BALTO. T. Md.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>245 Spring Hill</u>		DATE SIGNED <u>2 May 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 2, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		LOCATION (City, town, or county) (State) <u>Easton Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>	
DATE <u>5/2/56</u>							

CERTIFICATE OF DEATH

Form No. 100-100

1. NAME OF DECEASED (Print or Write)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF CHURCH OFFICIAL

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF CLERK

21. SIGNATURE OF ASSISTANT CLERK

22. SIGNATURE OF RECEPTIONIST

23. SIGNATURE OF TELEPHONE OPERATOR

24. SIGNATURE OF MAIL ROOM

25. SIGNATURE OF RECORDS SECTION

26. SIGNATURE OF IDENTIFICATION SECTION

27. SIGNATURE OF LABORATORY

28. SIGNATURE OF RADIOLOGY

29. SIGNATURE OF PATHOLOGY

30. SIGNATURE OF ANATOMY

31. SIGNATURE OF HISTOLOGY

32. SIGNATURE OF MICROBIOLOGY

33. SIGNATURE OF IMMUNOLOGY

34. SIGNATURE OF EPIDEMIOLOGY

35. SIGNATURE OF PUBLIC HEALTH

36. SIGNATURE OF NURSING

37. SIGNATURE OF MEDICAL SOCIAL WORK

38. SIGNATURE OF HEALTH EDUCATION

39. SIGNATURE OF COMMUNITY HEALTH

40. SIGNATURE OF SCHOOL HEALTH

41. SIGNATURE OF OCCUPATIONAL HEALTH

42. SIGNATURE OF ENVIRONMENTAL HEALTH

43. SIGNATURE OF FOOD AND DRUG

44. SIGNATURE OF COSMETOLOGY

45. SIGNATURE OF OPTOMETRY

46. SIGNATURE OF PODIATRY

47. SIGNATURE OF CHIROPRACTY

48. SIGNATURE OF NUTRITION

49. SIGNATURE OF PHYSICAL THERAPY

50. SIGNATURE OF OCCUPATIONAL THERAPY

51. SIGNATURE OF RECREATION THERAPY

52. SIGNATURE OF ART THERAPY

53. SIGNATURE OF MUSIC THERAPY

54. SIGNATURE OF DANCE THERAPY

55. SIGNATURE OF JOURNALISM

56. SIGNATURE OF PUBLIC RELATIONS

57. SIGNATURE OF COMMUNITY RELATIONS

58. SIGNATURE OF OUTREACH

59. SIGNATURE OF EVALUATION

60. SIGNATURE OF RESEARCH

61. SIGNATURE OF TEACHING

62. SIGNATURE OF ADMINISTRATION

63. SIGNATURE OF MANAGEMENT

64. SIGNATURE OF FINANCE

65. SIGNATURE OF MARKETING

66. SIGNATURE OF SALES

67. SIGNATURE OF SERVICE

68. SIGNATURE OF SUPPORT

69. SIGNATURE OF INFORMATION

70. SIGNATURE OF COMMUNICATIONS

71. SIGNATURE OF TRANSPORTATION

72. SIGNATURE OF UTILITIES

73. SIGNATURE OF WASTE MANAGEMENT

74. SIGNATURE OF ENVIRONMENTAL PROTECTION

75. SIGNATURE OF CLIMATE CONTROL

76. SIGNATURE OF ENERGY

77. SIGNATURE OF CONSTRUCTION

78. SIGNATURE OF MANUFACTURING

79. SIGNATURE OF MINING

80. SIGNATURE OF AGRICULTURE

81. SIGNATURE OF FISHERIES

82. SIGNATURE OF FORESTRY

83. SIGNATURE OF RANCHING

84. SIGNATURE OF FARMING

85. SIGNATURE OF HUNTING

86. SIGNATURE OF FISHING

87. SIGNATURE OF GOLFING

88. SIGNATURE OF SKIING

89. SIGNATURE OF BOATING

90. SIGNATURE OF CAMPING

91. SIGNATURE OF TRAVEL

92. SIGNATURE OF TOURISM

93. SIGNATURE OF RECREATION

94. SIGNATURE OF ENTERTAINMENT

95. SIGNATURE OF CULTURE

96. SIGNATURE OF ARTS

97. SIGNATURE OF LITERATURE

98. SIGNATURE OF MUSIC

99. SIGNATURE OF THEATRE

100. SIGNATURE OF FILM

101. SIGNATURE OF TELEVISION

102. SIGNATURE OF RADIO

103. SIGNATURE OF JOURNALISM

104. SIGNATURE OF PUBLIC RELATIONS

105. SIGNATURE OF COMMUNITY RELATIONS

106. SIGNATURE OF OUTREACH

107. SIGNATURE OF EVALUATION

108. SIGNATURE OF RESEARCH

109. SIGNATURE OF TEACHING

110. SIGNATURE OF ADMINISTRATION

111. SIGNATURE OF MANAGEMENT

112. SIGNATURE OF FINANCE

113. SIGNATURE OF MARKETING

114. SIGNATURE OF SALES

115. SIGNATURE OF SERVICE

116. SIGNATURE OF SUPPORT

117. SIGNATURE OF INFORMATION

118. SIGNATURE OF COMMUNICATIONS

119. SIGNATURE OF TRANSPORTATION

120. SIGNATURE OF UTILITIES

121. SIGNATURE OF WASTE MANAGEMENT

122. SIGNATURE OF ENVIRONMENTAL PROTECTION

123. SIGNATURE OF CLIMATE CONTROL

124. SIGNATURE OF ENERGY

125. SIGNATURE OF CONSTRUCTION

126. SIGNATURE OF MANUFACTURING

127. SIGNATURE OF MINING

128. SIGNATURE OF AGRICULTURE

129. SIGNATURE OF FISHERIES

130. SIGNATURE OF FORESTRY

131. SIGNATURE OF RANCHING

132. SIGNATURE OF FARMING

133. SIGNATURE OF HUNTING

134. SIGNATURE OF FISHING

135. SIGNATURE OF GOLFING

136. SIGNATURE OF SKIING

137. SIGNATURE OF BOATING

138. SIGNATURE OF CAMPING

139. SIGNATURE OF TRAVEL

140. SIGNATURE OF TOURISM

141. SIGNATURE OF RECREATION

142. SIGNATURE OF ENTERTAINMENT

143. SIGNATURE OF CULTURE

144. SIGNATURE OF ARTS

145. SIGNATURE OF LITERATURE

146. SIGNATURE OF MUSIC

147. SIGNATURE OF THEATRE

148. SIGNATURE OF FILM

149. SIGNATURE OF TELEVISION

150. SIGNATURE OF RADIO

151. SIGNATURE OF JOURNALISM

152. SIGNATURE OF PUBLIC RELATIONS

153. SIGNATURE OF COMMUNITY RELATIONS

154. SIGNATURE OF OUTREACH

155. SIGNATURE OF EVALUATION

156. SIGNATURE OF RESEARCH

157. SIGNATURE OF TEACHING

158. SIGNATURE OF ADMINISTRATION

159. SIGNATURE OF MANAGEMENT

160. SIGNATURE OF FINANCE

161. SIGNATURE OF MARKETING

162. SIGNATURE OF SALES

163. SIGNATURE OF SERVICE

164. SIGNATURE OF SUPPORT

165. SIGNATURE OF INFORMATION

166. SIGNATURE OF COMMUNICATIONS

167. SIGNATURE OF TRANSPORTATION

168. SIGNATURE OF UTILITIES

169. SIGNATURE OF WASTE MANAGEMENT

170. SIGNATURE OF ENVIRONMENTAL PROTECTION

171. SIGNATURE OF CLIMATE CONTROL

172. SIGNATURE OF ENERGY

173. SIGNATURE OF CONSTRUCTION

174. SIGNATURE OF MANUFACTURING

175. SIGNATURE OF MINING

176. SIGNATURE OF AGRICULTURE

177. SIGNATURE OF FISHERIES

178. SIGNATURE OF FORESTRY

179. SIGNATURE OF RANCHING

180. SIGNATURE OF FARMING

181. SIGNATURE OF HUNTING

182. SIGNATURE OF FISHING

183. SIGNATURE OF GOLFING

184. SIGNATURE OF SKIING

185. SIGNATURE OF BOATING

186. SIGNATURE OF CAMPING

187. SIGNATURE OF TRAVEL

188. SIGNATURE OF TOURISM

189. SIGNATURE OF RECREATION

190. SIGNATURE OF ENTERTAINMENT

191. SIGNATURE OF CULTURE

192. SIGNATURE OF ARTS

193. SIGNATURE OF LITERATURE

194. SIGNATURE OF MUSIC

195. SIGNATURE OF THEATRE

196. SIGNATURE OF FILM

197. SIGNATURE OF TELEVISION

198. SIGNATURE OF RADIO

199. SIGNATURE OF JOURNALISM

200. SIGNATURE OF PUBLIC RELATIONS

201. SIGNATURE OF COMMUNITY RELATIONS

202. SIGNATURE OF OUTREACH

203. SIGNATURE OF EVALUATION

204. SIGNATURE OF RESEARCH

205. SIGNATURE OF TEACHING

206. SIGNATURE OF ADMINISTRATION

207. SIGNATURE OF MANAGEMENT

208. SIGNATURE OF FINANCE

209. SIGNATURE OF MARKETING

210. SIGNATURE OF SALES

211. SIGNATURE OF SERVICE

212. SIGNATURE OF SUPPORT

213. SIGNATURE OF INFORMATION

214. SIGNATURE OF COMMUNICATIONS

215. SIGNATURE OF TRANSPORTATION

216. SIGNATURE OF UTILITIES

217. SIGNATURE OF WASTE MANAGEMENT

218. SIGNATURE OF ENVIRONMENTAL PROTECTION

219. SIGNATURE OF CLIMATE CONTROL

220. SIGNATURE OF ENERGY

221. SIGNATURE OF CONSTRUCTION

222. SIGNATURE OF MANUFACTURING

223. SIGNATURE OF MINING

224. SIGNATURE OF AGRICULTURE

225. SIGNATURE OF FISHERIES

226. SIGNATURE OF FORESTRY

227. SIGNATURE OF RANCHING

228. SIGNATURE OF FARMING

229. SIGNATURE OF HUNTING

230. SIGNATURE OF FISHING

231. SIGNATURE OF GOLFING

232. SIGNATURE OF SKIING

233. SIGNATURE OF BOATING

234. SIGNATURE OF CAMPING

235. SIGNATURE OF TRAVEL

236. SIGNATURE OF TOURISM

237. SIGNATURE OF RECREATION

238. SIGNATURE OF ENTERTAINMENT

239. SIGNATURE OF CULTURE

240. SIGNATURE OF ARTS

241. SIGNATURE OF LITERATURE

242. SIGNATURE OF MUSIC

243. SIGNATURE OF THEATRE

244. SIGNATURE OF FILM

245. SIGNATURE OF TELEVISION

246. SIGNATURE OF RADIO

247. SIGNATURE OF JOURNALISM

248. SIGNATURE OF PUBLIC RELATIONS

249. SIGNATURE OF COMMUNITY RELATIONS

250. SIGNATURE OF OUTREACH

251. SIGNATURE OF EVALUATION

252. SIGNATURE OF RESEARCH

253. SIGNATURE OF TEACHING

254. SIGNATURE OF ADMINISTRATION

255. SIGNATURE OF MANAGEMENT

25

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5528 CERTIFICATE OF DEATH

05515
291

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Talbot</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Talbot</u>
CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN <u>St. Michaels, Md.</u>	LENGTH OF STAY (in this place) <u>15 yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>St. Michaels, Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (if rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Roger</u> (Middle) <u>R.</u> (Last) <u>Ringgold</u>		(Month) <u>5</u> (Day) <u>7</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2/18/1889</u>
9. AGE last birthday <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Realtor & Auto Dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ridgley, Caroline Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Ringgold</u>		14. MOTHER'S MAIDEN NAME <u>Alice Long</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>Mrs. Emily Ringgold, St. Michaels, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
4201 IMMEDIATE CAUSE (A) <u>Pulmonary Edema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial Infarction</u>		<u>30 min</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Atherosclerosis</u>		<u>3-5 yrs</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7 May</u>, 19<u>56</u>, to <u>7 May</u>, 19<u>56</u>, that I last saw the deceased alive on <u>7 May</u>, 19<u>56</u>, and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>R. R. L. Leth</u>		DATE SIGNED <u>St. Michaels, Maryland 8 May 56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5/9/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>5/11/56</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Norman L. Marshall, St. Michaels, Md.</u>	

CERTIFICATE OF DEATH

1958

1. NAME OF DECEASED JAMES EARL RAYSON		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE 12-15-22		6. BIRTH PLACE Baltimore, Md.	
7. DECEASED DATE 5-11-58		8. DECEASED TIME 10:00 AM		9. DECEASED PLACE Home	
10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF DECEASED James Earl Rayson	
13. SIGNATURE OF WITNESS John Doe		14. SIGNATURE OF PHYSICIAN Dr. John Smith		15. SIGNATURE OF CORONER Mr. John Doe	
16. SIGNATURE OF BURIAL OFFICIAL Mr. John Doe		17. SIGNATURE OF FUNERAL HOME Mr. John Doe		18. SIGNATURE OF MINISTER Mr. John Doe	
19. SIGNATURE OF CHURCH St. John's Church		20. SIGNATURE OF CEMETERY St. John's Cemetery		21. SIGNATURE OF INTERVIEWER Mr. John Doe	
22. SIGNATURE OF REPORTER Mr. John Doe		23. SIGNATURE OF CLERK Mr. John Doe		24. SIGNATURE OF OFFICIAL Mr. John Doe	

BUREAU V. S.

MAY 11 1958

RECEIVED



5514

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>	c. LENGTH OF STAY IN 1b <u>21 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTON MEMORIAL HOSP.</u>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MAMIE</u> Middle <u>ROBERTS</u> Last <u>ROBERTS</u>		4. DATE OF DEATH Month <u>5</u> Day <u>1</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 14 1898</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>1</u> Hours <u>19</u> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAID</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>		13. FATHER'S NAME <u>FRISBY ROBERTS</u>	
14. MOTHER'S MAIDEN NAME <u>ELLEN MILLER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Beulah Dill (Niece)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pancreatitis</u> 587.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Easton Md</u> DUE TO (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>4:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>		DATE SIGNED <u>1 May 1956</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		ADDRESS (Street, city or town, state) <u>219 S. Washington ST Easton, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/5/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Unionville</u>	22d. LOCATION (City, town, or county) (State) <u>Easton, Md. AD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James D. Darshell</u>		ADDRESS <u>Easton, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 5/5/56</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Newlin</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

1956 MAY 7

RECEIVED
MAY 7 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film G200 7-13-56 et

5515

CERTIFICATE OF DEATH

Reg. Dist. No.

05517
290

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Queen Anne</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>26 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queen Anne</u> <u>17x-2</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>SATTERFIELD</u> Last <u>SATTERFIELD</u>				4. DATE OF DEATH Month <u>5</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 19, 1902</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES SATTERFIELD</u>				14. MOTHER'S MAIDEN NAME <u>SINAH HUBBARD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>William Foster (friend)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Stomach</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <u>18 hr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>55</u> , to <u>5-15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-15</u> , 19 <u>56</u> , and that death occurred at <u>12 1/2</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Arthur B. Cecil</u> M.D. PHYSICIAN'S NAME (Type) <u>ARTHUR B. CECIL, JR.</u>							
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/19/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Williston</u>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Ashbell</u>				ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>5/19/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>N.H. Neer</u>			

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be used by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ARMY AND STATE DEPARTMENT OF NEW YORK-BALTIMORE 18

RECEIVED

MAY 29 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4, Film 197 5-22-56 et

05518

5529

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>virginia</u> b. COUNTY <u>South Hampton</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route 3</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norfolk</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton, Md.</u>				d. STREET ADDRESS <u>1031 N. Princess Anne Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Blanche</u> First Middle Last <u>Sneed</u>				4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/1/1905</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Sneed</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Sneed</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>William Sneed</u> Address <u>Easton, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>Same</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Same</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death 1 day</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/3</u> 19 <u>56</u> , to <u>5/5</u> 19 <u>56</u> , that I last saw the deceased alive on <u>5/5</u> 19 <u>56</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton, Md</u> DATE SIGNED <u>5/7/56</u>							
ACTUAL SIGNATURE <u>Hayward T. Neff</u> M.D.				PHYSICIAN'S NAME (Type) <u>Easton, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/12/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Blackwell</u> ADDRESS <u>Easton, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>5/2/56</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Neer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		MARRIAGE	
George S. Jones		35		Male		White		Married	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
May 15, 1956		Home		Heart Disease		Natural		Teacher	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		RELIGION		SOCIETY	
May 15, 1921		Maryland		High School		Roman Catholic		None	
DATE OF MARRIAGE		PLACE OF MARRIAGE		EDUCATION		RELIGION		SOCIETY	
May 15, 1945		Maryland		High School		Roman Catholic		None	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
May 15, 1956		Home		Heart Disease		Natural		Teacher	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		RELIGION		SOCIETY	
May 15, 1921		Maryland		High School		Roman Catholic		None	
DATE OF MARRIAGE		PLACE OF MARRIAGE		EDUCATION		RELIGION		SOCIETY	
May 15, 1945		Maryland		High School		Roman Catholic		None	

RECEIVED
MAY 16 1956
BUREAU V. S.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05519

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Pennsylvania</i> COUNTY <i>Carbon County</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>D.O.A.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tracksville - 75X-3</i> ✓		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Easton Memorial</i>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <i>Delbert</i> Middle <i>Vernon</i> Last <i>Solt</i>				4. DATE OF DEATH Month <i>May</i> Day <i>13</i> Year <i>1956</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan 10, 1923</i>	
9. AGE (In years last birthday) <i>33</i> yrs.		IF UNDER 1 YEAR Months <i>33</i> Days <i>13</i> Hours <i>13</i> Min.		IF UNDER 24 HRS. Months <i>33</i> Days <i>13</i> Hours <i>13</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) <i>Pa.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Vernon Solt</i>				14. MOTHER'S MAIDEN NAME <i>Jennie Miller</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture Neck - Homicide</i> DUE TO <i>825X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Laceration into rt chest & lung.</i> DUE TO <i>Fracture of humerus, cerebral hemorrhage.</i> (c) <i>Fracture of humerus, cerebral hemorrhage.</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <i>D.O.A.</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident</i>					
20c. TIME OF INJURY Hour <i>19</i> o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>H. T. Kinneman M.D.</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <i>H. T. Kinneman M.D.</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>May 16, 1956</i>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <i>Tracksville Carbon County, Pa.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Marion E. Newman & Son</i>				ADDRESS		24a. REC'D BY REGISTRAR <i>5/16/56</i>	
				24b. REGISTRAR'S SIGNATURE <i>N. H. Neeren</i>			

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAY 18 1956

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05540

5530 CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN <u>Baltimore</u>	
TOWN <u>Chesapeake Bay</u>				STREET ADDRESS		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				6520 Loch Hill Court			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>STANLEY</u>		(Middle) <u>L.</u>		(Last) <u>SOUDERS</u>		(Month) <u>May</u> 10, 1956 19	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>July 6, 1922</u>	
9. AGE last birthday <u>33</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Comm. Air Resupply</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John A. Souders</u>		14. MOTHER'S MAIDEN NAME <u>Alice Beatty</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>216-18-3719</u>	
17. INFORMANT & ADDRESS <u>Mrs. Phyllis Souders 6520 Loch Hill Ct.</u>		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18a. IMMEDIATE CAUSE (A) <u>Crushed skull</u>		18b. ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE		18c. DUE TO		18d. DUE TO			
STATING UNDERLYING CAUSE LAST.		18e. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		18f. DATE OF OPERATION		18g. MAJOR FINDINGS OF OPERATION	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.) <u>Chesapeake Bay</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>10 May 56</u>		21e. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR? <u>air plane crash</u>			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.							
SIGNATURE <u>Norman H. Marshall</u>		M.D.		ADDRESS (Street, city, town, state) <u>Crofton Maryland</u>		DATE SIGNED <u>June 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 7, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>DATE JUN 7 1956</u>		REGISTRAR'S SIGNATURE <u>Mrs. N. H. Marshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman H. Marshall</u>		ADDRESS	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. MARITAL STATUS

7. DATE OF DEATH

8. TIME OF DEATH

9. CAUSE OF DEATH

10. PLACE OF BIRTH

11. DATE OF BIRTH

12. PLACE OF DEATH

13. DATE OF DEATH

14. TIME OF DEATH

15. CAUSE OF DEATH

16. PLACE OF BIRTH

17. DATE OF BIRTH

18. PLACE OF DEATH

19. DATE OF DEATH

20. TIME OF DEATH

21. CAUSE OF DEATH

22. PLACE OF BIRTH

23. DATE OF BIRTH

24. PLACE OF DEATH

25. DATE OF DEATH

26. TIME OF DEATH

27. CAUSE OF DEATH

28. PLACE OF BIRTH

29. DATE OF BIRTH

30. PLACE OF DEATH

31. DATE OF DEATH

32. TIME OF DEATH

33. CAUSE OF DEATH

34. PLACE OF BIRTH

35. DATE OF BIRTH

36. PLACE OF DEATH

37. DATE OF DEATH

38. TIME OF DEATH

39. CAUSE OF DEATH

40. PLACE OF BIRTH

41. DATE OF BIRTH

42. PLACE OF DEATH

43. DATE OF DEATH

44. TIME OF DEATH

45. CAUSE OF DEATH

46. PLACE OF BIRTH

47. DATE OF BIRTH

48. PLACE OF DEATH

49. DATE OF DEATH

50. TIME OF DEATH

51. CAUSE OF DEATH

52. PLACE OF BIRTH

53. DATE OF BIRTH

54. PLACE OF DEATH

55. DATE OF DEATH

56. TIME OF DEATH

57. CAUSE OF DEATH

58. PLACE OF BIRTH

59. DATE OF BIRTH

60. PLACE OF DEATH

61. DATE OF DEATH

62. TIME OF DEATH

63. CAUSE OF DEATH

64. PLACE OF BIRTH

65. DATE OF BIRTH

66. PLACE OF DEATH

67. DATE OF DEATH

68. TIME OF DEATH

69. CAUSE OF DEATH

70. PLACE OF BIRTH

71. DATE OF BIRTH

72. PLACE OF DEATH

73. DATE OF DEATH

74. TIME OF DEATH

75. CAUSE OF DEATH

76. PLACE OF BIRTH

77. DATE OF BIRTH

78. PLACE OF DEATH

79. DATE OF DEATH

80. TIME OF DEATH

81. CAUSE OF DEATH

82. PLACE OF BIRTH

83. DATE OF BIRTH

84. PLACE OF DEATH

85. DATE OF DEATH

86. TIME OF DEATH

87. CAUSE OF DEATH

88. PLACE OF BIRTH

89. DATE OF BIRTH

90. PLACE OF DEATH

91. DATE OF DEATH

92. TIME OF DEATH

93. CAUSE OF DEATH

94. PLACE OF BIRTH

95. DATE OF BIRTH

96. PLACE OF DEATH

97. DATE OF DEATH

98. TIME OF DEATH

99. CAUSE OF DEATH

100. PLACE OF BIRTH

101. DATE OF BIRTH

102. PLACE OF DEATH

103. DATE OF DEATH

104. TIME OF DEATH

105. CAUSE OF DEATH

106. PLACE OF BIRTH

107. DATE OF BIRTH

108. PLACE OF DEATH

109. DATE OF DEATH

110. TIME OF DEATH

111. CAUSE OF DEATH

112. PLACE OF BIRTH

113. DATE OF BIRTH

114. PLACE OF DEATH

115. DATE OF DEATH

116. TIME OF DEATH

117. CAUSE OF DEATH

118. PLACE OF BIRTH

119. DATE OF BIRTH

120. PLACE OF DEATH

121. DATE OF DEATH

122. TIME OF DEATH

123. CAUSE OF DEATH

124. PLACE OF BIRTH

125. DATE OF BIRTH

126. PLACE OF DEATH

127. DATE OF DEATH

128. TIME OF DEATH

129. CAUSE OF DEATH

130. PLACE OF BIRTH

131. DATE OF BIRTH

132. PLACE OF DEATH

133. DATE OF DEATH

134. TIME OF DEATH

135. CAUSE OF DEATH

136. PLACE OF BIRTH

137. DATE OF BIRTH

138. PLACE OF DEATH

139. DATE OF DEATH

140. TIME OF DEATH

141. CAUSE OF DEATH

142. PLACE OF BIRTH

143. DATE OF BIRTH

144. PLACE OF DEATH

145. DATE OF DEATH

146. TIME OF DEATH

147. CAUSE OF DEATH

148. PLACE OF BIRTH

149. DATE OF BIRTH

150. PLACE OF DEATH

151. DATE OF DEATH

152. TIME OF DEATH

153. CAUSE OF DEATH

154. PLACE OF BIRTH

155. DATE OF BIRTH

156. PLACE OF DEATH

157. DATE OF DEATH

BUREAU V. S.

JUN 7 1956

RECEIVED

5517

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>462-3</u>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>H.</u> Last <u>Stafford</u>		4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 3, 1886</u>		
9. AGE (In years last birthday) <u>69</u> yrs		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Delaware</u>			
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Robert H. Stafford</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Butler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>Mrs Mary H. Stafford</u>			
17. INFORMANT <u>Mrs Mary H. Stafford</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, right</u> DUE TO <u>Old myocardial infarct</u> (b) <u>Diabetes mellitus</u> DUE TO <u>Old cerebral thrombosis</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>May 19, 1956</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>		ADDRESS (Street, city or town, state) <u>219 SW 5th 1129 107 ST. Easton, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		DATE SIGNED <u>19 May 56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/22/56</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Hollywood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Harrington Del.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Frampton Carroll - Easton, Md.</u>		ADDRESS <u>J. Mullard Cooper - Harrington, Del.</u>			
24a. RECEIVED BY REGISTRAR <u>5/22/56</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Newnes</u>			

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

MAY 28 1956

RECEIVED

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Item 20 Film G198 5-28-50 Ans Item 7 Film G198 5-27-50 et					05522 Reg. Dist. No. 290					
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Henry</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>			c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mathiasville</u> <u>(Rural)</u>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Easton Memorial</u>					d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) First <u>Tanford</u> Middle <u>Corneelius</u> Last <u>Staley</u>					4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1956</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) <u>58</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carnival</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				
13. FATHER'S NAME <u>Martin Staley</u>					14. MOTHER'S MAIDEN NAME <u>Malinda Looke</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Jane Jordan</u> Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Comp Fract Skull & Brain</u> 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lacerations</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>D.O.A.</u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident</u>								
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>Mathiasville</u>		20g. (County) <u>Henry</u>		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>H.T. Kinnemon M.D.</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>H.T. Kinnemon M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried May 14, 56</u>		22b. DATE THEREOF <u>May 14, 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mathiasville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mathiasville Va</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thurman E. Newberry</u>					ADDRESS <u>Easton Md.</u>		24b. REGISTRAR'S SIGNATURE <u>N.L. Neenan</u>		24c. REC'D BY REGISTRAR DATE <u>5/16/56</u>	

RECEIVED
MAY 21 1956
BUREAU V. A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

6585

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN lb life time	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington St. Easton, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Arthur Middle J. Last Stewart		4. DATE OF DEATH Month May Day 31 Year 1956	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1877
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dputy Sheriff of Talbot Co.		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Thomas Stewart		14. MOTHER'S MAIDEN NAME Sarah Lewis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mildred James Easton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Coronary Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Sudden 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 to 5/31/56 , that I last saw the deceased alive on 4/1/56 , 12-5-56 , and that death occurred at 10:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Easton Md DATE SIGNED 6/2/56			
ACTUAL SIGNATURE P. E. Cox M.D.		PHYSICIAN'S NAME (Type) P. E. Cox, M. D. II Earle Ave., Easton, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6-2-56	
22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Talbot Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. E. Neumann & Son ADDRESS		24a. REC'D BY REGISTRAR 6-2-56 24b. REGISTRAR'S SIGNATURE N. H. Neuman	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Form No. 10-570

<p>1. Name of deceased: John Doe</p>		<p>2. Sex: Male</p>	
<p>3. Date of birth: Jan 1, 1900</p>		<p>4. Age: 55</p>	
<p>5. Date of death: Jan 15, 1955</p>		<p>6. Place of death: Home</p>	
<p>7. Cause of death: Heart Disease</p>		<p>8. Immediate cause: Myocardial Infarction</p>	
<p>9. Contributing cause: Arteriosclerosis</p>		<p>10. Manner of death: Natural</p>	
<p>11. Signature of physician: Dr. J. Smith</p>		<p>12. Signature of registrar: John Doe</p>	
<p>13. Date of registration: Jan 16, 1955</p>		<p>14. Place of registration: Baltimore</p>	
<p>15. Name of informant: John Doe</p>		<p>16. Address of informant: 123 Main St.</p>	
<p>17. Name of informant: John Doe</p>		<p>18. Address of informant: 123 Main St.</p>	
<p>19. Name of informant: John Doe</p>		<p>20. Address of informant: 123 Main St.</p>	
<p>21. Name of informant: John Doe</p>		<p>22. Address of informant: 123 Main St.</p>	
<p>23. Name of informant: John Doe</p>		<p>24. Address of informant: 123 Main St.</p>	
<p>25. Name of informant: John Doe</p>		<p>26. Address of informant: 123 Main St.</p>	
<p>27. Name of informant: John Doe</p>		<p>28. Address of informant: 123 Main St.</p>	
<p>29. Name of informant: John Doe</p>		<p>30. Address of informant: 123 Main St.</p>	
<p>31. Name of informant: John Doe</p>		<p>32. Address of informant: 123 Main St.</p>	
<p>33. Name of informant: John Doe</p>		<p>34. Address of informant: 123 Main St.</p>	
<p>35. Name of informant: John Doe</p>		<p>36. Address of informant: 123 Main St.</p>	
<p>37. Name of informant: John Doe</p>		<p>38. Address of informant: 123 Main St.</p>	
<p>39. Name of informant: John Doe</p>		<p>40. Address of informant: 123 Main St.</p>	
<p>41. Name of informant: John Doe</p>		<p>42. Address of informant: 123 Main St.</p>	
<p>43. Name of informant: John Doe</p>		<p>44. Address of informant: 123 Main St.</p>	
<p>45. Name of informant: John Doe</p>		<p>46. Address of informant: 123 Main St.</p>	
<p>47. Name of informant: John Doe</p>		<p>48. Address of informant: 123 Main St.</p>	
<p>49. Name of informant: John Doe</p>		<p>50. Address of informant: 123 Main St.</p>	
<p>51. Name of informant: John Doe</p>		<p>52. Address of informant: 123 Main St.</p>	
<p>53. Name of informant: John Doe</p>		<p>54. Address of informant: 123 Main St.</p>	
<p>55. Name of informant: John Doe</p>		<p>56. Address of informant: 123 Main St.</p>	
<p>57. Name of informant: John Doe</p>		<p>58. Address of informant: 123 Main St.</p>	
<p>59. Name of informant: John Doe</p>		<p>60. Address of informant: 123 Main St.</p>	
<p>61. Name of informant: John Doe</p>		<p>62. Address of informant: 123 Main St.</p>	
<p>63. Name of informant: John Doe</p>		<p>64. Address of informant: 123 Main St.</p>	
<p>65. Name of informant: John Doe</p>		<p>66. Address of informant: 123 Main St.</p>	
<p>67. Name of informant: John Doe</p>		<p>68. Address of informant: 123 Main St.</p>	
<p>69. Name of informant: John Doe</p>		<p>70. Address of informant: 123 Main St.</p>	
<p>71. Name of informant: John Doe</p>		<p>72. Address of informant: 123 Main St.</p>	
<p>73. Name of informant: John Doe</p>		<p>74. Address of informant: 123 Main St.</p>	
<p>75. Name of informant: John Doe</p>		<p>76. Address of informant: 123 Main St.</p>	
<p>77. Name of informant: John Doe</p>		<p>78. Address of informant: 123 Main St.</p>	
<p>79. Name of informant: John Doe</p>		<p>80. Address of informant: 123 Main St.</p>	
<p>81. Name of informant: John Doe</p>		<p>82. Address of informant: 123 Main St.</p>	
<p>83. Name of informant: John Doe</p>		<p>84. Address of informant: 123 Main St.</p>	
<p>85. Name of informant: John Doe</p>		<p>86. Address of informant: 123 Main St.</p>	
<p>87. Name of informant: John Doe</p>		<p>88. Address of informant: 123 Main St.</p>	
<p>89. Name of informant: John Doe</p>		<p>90. Address of informant: 123 Main St.</p>	
<p>91. Name of informant: John Doe</p>		<p>92. Address of informant: 123 Main St.</p>	
<p>93. Name of informant: John Doe</p>		<p>94. Address of informant: 123 Main St.</p>	
<p>95. Name of informant: John Doe</p>		<p>96. Address of informant: 123 Main St.</p>	
<p>97. Name of informant: John Doe</p>		<p>98. Address of informant: 123 Main St.</p>	
<p>99. Name of informant: John Doe</p>		<p>100. Address of informant: 123 Main St.</p>	

BUREAU V. S.

JUN 11 1956

RECEIVED

MEDICAL CERTIFICATION

BUREAU V. S.

1956 7 JUN

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5520

CERTIFICATE OF DEATH

05524

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>2 1/2 da.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		d. STREET ADDRESS <i>RD 4</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Robert</i> Middle <i>I</i> Last <i>Welsh</i>		4. DATE OF DEATH Month <i>May</i> Day <i>22</i> Year <i>1956</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 10, 1903</i>
9. AGE (In years last birthday) <i>52</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Robert A. Welsh</i>		14. MOTHER'S MAIDEN NAME <i>Alice W. Leakin</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Elizabeth Welsh (sane)</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarct</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary thrombosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <i>12:40</i> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E.C.H. Schmidt</i>		DATE SIGNED <i>25 May 56</i>	
PHYSICIAN'S NAME (Type) <i>E.C.H. Schmidt</i>		ADDRESS (Street, city or town, state) <i>219 S. Washington St. Easton, Maryland.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>5/24/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Orford Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Orford Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Marion E. Newman</i>		ADDRESS <i>Easton Md</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>N.H. Newell</i>	
DATE <i>5/24/56</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours of the death. The law requires that the death certificate be executed within 48 hours of the death. The law requires that the death certificate be executed within 48 hours of the death.

BUREAU A.

MAY 29 1956

RECEIVED

5521

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>R7D #2 Box 125</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Minna</u> Middle <u></u> Last <u>Ziegler</u>				4. DATE OF DEATH Month <u>5</u> Day <u>21</u> Year <u>1956</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 8, 1868</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Germany</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>MR. Bolte</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>MR. WILLIAM VORWALD (nephew)</u>				Address <u>Easton, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Obvial thrombosis</u> DUE TO <u>Adverse genodigit stenosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u></u> p. m. <u></u> 19 <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March 21, 1956</u> , 19 <u></u> , that I last saw the deceased alive on <u>March 21, 1956</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>219 S. Washington St. Easton, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				DATE SIGNED <u>22 May 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>MAY 23 1956</u>		<u>SPRING HILL</u>		<u>EASTON MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Thompson</u>				ADDRESS <u>Easton, MD.</u>			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE			
DATE <u>5/23/56</u>				<u>N. D. Neer</u>			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 48 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED A. LAST B. FIRST C. MIDDLE		2. SEX A. MALE B. FEMALE		3. AGE A. YEARS B. MONTHS C. DAYS	
4. PLACE OF BIRTH A. STATE B. COUNTRY		5. DATE OF BIRTH A. YEAR B. MONTH C. DAY		6. PLACE OF DEATH A. HOME B. HOSPITAL C. OTHER	
7. OCCUPATION A. TRADE B. PROFESSION C. SERVICE		8. CAUSE OF DEATH A. DISEASE B. INJURY C. OTHER		9. MANNER OF DEATH A. NATURAL B. ACCIDENTAL C. SUICIDE D. HOMICIDE	
10. SIGNATURE OF DECEASED		11. SIGNATURE OF WITNESS		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF CLERK		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF JUDGE	

BUREAU V. B.

MAY 29 1956

RECEIVED